

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1686

State File No. _____

Registration District No. 53

Primary Registration District No. 3005

Registrar's No. 3

1. PLACE OF DEATH:

(a) County BATES
(b) City or town Rich Hill Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether

In this community 90 YRS-
years, months or days)

3. (a) PRINT FULL NAME SUSAN ANN McGinnis

3. (b) If veteran, name war X 3. (c) Social Security No. X

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, 2 divorced

6. (b) Name of husband or wife G. D. McGinnis 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug 7-1846
(Month) (Day) (Year)

8. AGE: Years 94 Months 4 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace W. VIRGINIA (City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business

MOTHER FATHER { 12. Name OLANDO MERCHANT
13. Birthplace W. VIRGINIA (City, town, or county) (State or foreign country)
14. Maiden name REBECCA BAKER
15. Birthplace W. VIRGINIA (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Harue McGinnis

(b) Address Rich Hill Mo

17. (a) BURIAL (b) Date thereof JAN-7-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GREENLAWN

18. (a) Signature of funeral director Booth Sevier

(b) Address Rich Hill Mo

19. (a) Jan. 7, 1944 (b) Claude J. Allen M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County BATES
(c) City or town Rich Hill Mo
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 6
year 1944 hour 2 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from Jan 5, 1944, to Jan 6, 1944;
that I last saw him alive on Jan 4, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Dyspnea, Emphysema
Due to Smoking

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 56
(Specify type of place) (e) Means of injury _____

23. Signature Claude J. Allen (M. D. or other) MD
Address Rich Hill Mo Date signed 1/7/44

1122

RECEIVED

District Health Officer No. 7,

District File Number 2-41-250

Date Filed 2-6-41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

Registered Apprentice No.

working under my personal supervision.

Signed

John H. Underwood

Licensed Embalmer No. 3585

P. O. Address Butler Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 1686

Registration District No. 53

Primary Registration District No. 3005

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Bates
(b) City or town Rich Hill
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

Susan Ann McGinnis

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 94 Months 4 Days 29 If less than one day _____ min.

9. Birthplace (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U.S.A.? _____ years

20. DATE OF DEATH Month Jan day 6 year 1991 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death hypostatic pneumonia
semility

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 107

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed 4/10/91

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

S-1686